Physicians Health Plan Plus

Benefit Summary 40100-826-10

TYPE OF BENEFITS	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
	The benefits below are covered when provided by Physicians Health Plan of Mid-Michigan participating providers.	The benefits below are covered when received through non-participating providers. Some services require notification. If we are not notified when required, benefits will be reduced or not covered. Refer to your Certificate of Coverage for notification requirements.
ANNUAL DEDUCTIBLE	None	$200 per person/$400 per family per calendar year
LIFETIME MAXIMUM	Unlimited	Unlimited
	AMOUNT COVERED	**AMOUNT COVERED**
PHYSICIAN OFFICE VISITS		
Office visits for illness or injury	All charges over $10 per visit	80% of Eligible Expenses (EE) after deductible
Physical exams	All charges over $10 per visit	Not covered
Well baby care	All charges over $10 per visit	Not covered
Immunizations	100%	Not covered
Family planning; birth control devices; voluntary sterilization	All charges over $10 per visit	Not covered
Vision exams	Not covered	Not covered
Maternity care (pre and postnatal services)	100%	80% of EE after deductible
Injections	100%	80% of EE after deductible (Note: prior notification is not required for services in a physician's office)
INPATIENT HOSPITAL		
Unlimited days in a semi-private room	100%	80% of EE after deductible
Special care units	100%	80% of EE after deductible
Necessary ancillary hospital services	100%	80% of EE after deductible
Surgery and related services	100%	80% of EE after deductible
Anesthesia and its administration	100%	80% of EE after deductible
Transplant services (at designated facilities)	100%	Not covered
Maternity care (hospital services)	100%	80% of EE after deductible
Physician services including consultation	100%	80% of EE after deductible
Physician obstetrical services	100%	80% of EE after deductible
OUTPATIENT HOSPITAL		
Surgery and related services	100%	80% of EE after deductible
Diagnostic X-ray and laboratory	100%	80% of EE after deductible
CT scans, PET scans, MRI and Nuclear Medicine	100%	80% of EE after deductible
Voluntary sterilization	100%	80% of EE after deductible (Note: prior notification is not required for outpatient hospital services)

TYPE OF BENEFITS	IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
	AMOUNT COVERED	AMOUNT COVERED
EMERGENCY CARE		
At hospital emergency room	All charges over $50 per visit *(waived if admitted for an inpatient stay)*	Covered as an in-network benefit
At urgent care facility (after-hour services)	All charges over $10 per visit	Covered as an in-network benefit
MENTAL HEALTH, ALCOHOLISM & SUBSTANCE ABUSE SERVICES		
Inpatient/Intermediate mental health	45 days at 100%, renewable after 60 days	Not covered
Outpatient mental health	Up to 20 visits per calendar year covered in full; $10/half session $15/full session thereafter	80% of EE *(limited to 20 visits per calendar year; not subject to annual deductible)*
Intermediate care services for alcoholism, substance abuse	100% *(maximums apply)*	80% of EE after deductible *(maximums apply)*
Inpatient substance abuse services	100% coverage for one program (not to exceed 45 days) renewable after 60 days	80% of EE after dedictible *(maximum $1000 per year)*
Outpatient services for alcoholism, substance abuse	100% *(up to 35 visits per calendar year)*	80% of EE after deductible *(maximums apply)* (Note: prior notification is not required for MH/SA services)
OTHER SERVICES		
Home health agency services	100% *(up to 60 visits per calendar year)*	80% of EE after deductible *(combined network and non-network benefits limited to 60 visits per calendar year)*
Skilled nursing facility services	100% *(no annual limit)*	80% of EE after deductible *(limitations apply)*
Hospice care	100%	80% of EE after deductible *(limitations apply)*
Ambulance services	100%	Covered as an in-network benefit
Prosthetics	100% *(limitations apply)*	80% of EE after deductible *(limitations apply)*
Durable medical equipment	100% *(limitations apply)*	80% of EE after deductible *(limitations apply)*
Outpatient rehabilitation services (up to 60 visits per calendar year for physical, speech, occupational and pulmonary; up to 36 visits per calendar year for cardiac rehabilitation)	All charges over $10 per visit *(limitations apply)*	80% of EE after deductible *(combined network and non-network limitations apply; prior notification is not required)*
Infertility services	100% *(maximums apply)*	Not covered
Hearing aid services	Either one monaural to a maximum benefit of $880 or one binaural hearing aid to a maximum benefit of $1600 every 36 months	Not covered
Chiropractic services	All charges over $10 per visit; limited to 20 visits per calendar year	Not covered

IN-NETWORK BENEFITS	NON-NETWORK BENEFITS
Except in an emergency, medically necessary and preventive health care services must be provided, arranged or authorized through Physicians Health Plan of Mid-Michigan and its participating physicians to qualify for in-network benefits. All referrals to non-PHPMM providers require prior plan approval. All mental health, alcoholism and substance abuse services must be provided or authorized in advance by the plan's Mental Health/Substance Abuse Designee. Maximum copayments for all health services per calendar year: $3000 per covered person (not to exceed $6000 per family). Copayments charged as a flat dollar amount (instead of as a percentage of eligible expenses) do not apply to this maximum.	Only medically necessary services that are a result of an injury or sickness are covered. In general, health services provided through a non-PHPMM provider must be authorized in advance. Failure to provide prior notification when required may result in reduced benefits, and in some instances benefits may be denied. Without prior notification, benefits will be reduced to 50% except durable medical equipment and prosthetics which will be denied. All medical services are subject to an annual deductible. The annual deductible is $200 per covered person not to exceed $400 per family every calendar year. After the deductible has been satisfied, eligible expenses are covered at the percentages indicated. Under this coverage your maximum out-of-pocket expense is limited to $3000 per person, or $3000 per family, per calendar year. The out-of-pocket maximum does not include the annual deductible.

Member materials, including the PHPMM PHP Plus Certificate of Coverage, can be found online at our Member Packet Portal. Members may access the Member Packet Portal through our web site at www.phpmm.org

NOTE: This policy is not subject to a pre-existing condition limitation.

Except as may be specifically provided through a Rider to the policy, exclusions include:

- Dental care
- Cosmetic surgery
- Experimental procedures
- Hearing aids
- Prescription drugs
- Non-Network charges in excess of the Eligible Expenses as determined in accordance with our reimbursement policy guidelines
- Custodial care, bed care, convenience care, day care, domiciliary care

For additional information about exclusions, contact the PHPMM Customer Services Department or review the PHPMM PHP Plus Certificate of Coverage for this benefit plan.

This Summary of Benefits is intended only to highlight the benefits provided under PHP Plus and should not be relied upon to fully determine coverage. This health plan may not cover all health care expenses. Please refer to the Physicians Health Plan of Mid-Michigan (PHPMM) PHP Plus Certificate of Coverage for a complete listing of covered services, limitations and exclusions and a description of all the terms and conditions of coverage. If this description conflicts in any way with the policy issued to the enrolling group, the policy will prevail. For answers to questions about information which appears in the summary, call our Customer Service Department at (517) 364-8500 or (800) 832-9186.

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